STATE OF UTAH
DEPARTMENT OF HUMAN SERVICES
Office of Recovery Services Child Support Services

PURPOSE:

This agreement is between the Utah State Department of Human Services, *Office of Recovery Services/Child Support Services,* herein after referred to as *ORS,* and, _____ _____, herein after referred to as the *Financial Institution.* This Agreement establishes requirements to be met by the *ORS* and *the Financial Institutio*n, pursuant to Utah Code Annotated 62A-11-304.5 and section 466(a)(17) of the Social Security Act, for the purpose of developing and operating a data match system. The *Financial Institution* shall participate in the automated exchange of data by providing, on a quarterly basis, identifying information for each non-custodial parent who maintains an account at such institution and who owes past-due support, as identified by the *ORS*. The automated data exchange system will be implemented and managed through the child support enforcement program of the *ORS* and/or its authorized agent.

Financial Institution agrees to the following:

1. Submit the required data quarterly using one of the approved methods.
2. Submit for reimbursement based on incurred cost using the reimbursement request form.
3. Contact the ORS FIDM Program Specialist with any questions or concerns.
4. Protect the confidentiality of any data/information supplied to the financial institution by ORS.

Office of Recovery Services/Child Support Services agrees to the following*:*

1. Maintain an FTP site and provide alternate options for receiving/submitting data to financial institutions.
2. Accept and process data received within 30 days.
3. Reimburse Financial Institution based on quarterly incurred cost.
4. Provide information as needed.

ACTION:

To participate, the *Financial Institution* should sign and return this Agreement within 30 days of receipt.

PARTIES TO THE AGREEMENT:

Jessica Castor	
FIDM Program Specialist	Contact Name
Office of Recovery Services	
Agency	Institution Name
PO Box 45033	
Address	Address
Salt Lake City, UT 84145-0033	
City State Zip	City State Zip
orsfidm@utah.gov	
E-mail Address	E-mail Address
(801) 536-8902 (801) 536-8509	
Phone Fax	Phone Fax

DATA ELEMENTS AND REQUIREMENTS:

All data supplied under this Agreement as required below shall be in accordance with the Financial Data Match Specifications Handbook. (Published September 2004).

TRANSMITTING METHODS:

The following are the accepted data transfer methods used by the *ORS*. Please indicate the type of data transfer method your institution will use.

- ☐ FTP
  - METHOD 1 (All accounts method)
  - METHOD 2 (Matched Accounts method)
  - IP Address_____
- ☐ 3490E Cartridges
  - METHOD 1 (All accounts method)
  - METHOD 2 (Matched Accounts method)

- ☐ MANUAL MATCH (600 accounts or fewer)
  - METHOD 1

Those institutions electing to receive a 3490E cartridge will be required to return the data on a 3490E cartridge. Institutions are advised that the *ORS* will return all used tapes/cartridges to the initiating *Financial Institution.* The *ORS* will require the return of the *ORS* tapes/cartridges after the completion of each quarterly match. Retention of the used tapes/cartridges will result in a charge to the financial institution for the cost of the replacement.

AGENT:

The *Financial Institution* may designate an agent to perform the data match on its behalf by completing the information below.

Agent: _____

Contact Person: _____

Title: _____

Street Address: _____

Mailing Address (if different)_____ Telephone_____

Fax: _____ E-mail: _____

COSTS AND FEES:

In accordance with UCA 62A-11-304.5, the *ORS* may pay a reasonable fee to a *Financial Institution* for compliance with this program. The reimbursement may not exceed the actual costs of the transference and matching of data. The reimbursement does not include programming costs and will not exceed $150.00 per quarter.

ORS must receive the FM01 Reimbursement form along with supporting documentation no later than 30 days after the end of the quarter. For example, first quarter reporting is from January to March. The reimbursements need to be submitted to ORS before April 30th. We will accept your form by U.S mail or fax. Reimbursement requests that are received after the 30 days will not be reimbursed. If you have further questions regarding this process please refer to page 4 in the FIDM manual or to your FIDM contract. Please send reimbursement requests attention to:

Attention: Jessica Castor
FIDM Program Specialist
Office of Recovery Services
PO Box 45033
Salt Lake City UT 84145-0033
Desk: (801) 536-8902 Fax: (801) 536-8509 E-mail: orsfidm@utah.gov

ADDITIONAL TERMS:

AGREEMENT PERIOD: Effective_____. Terminates on _____.
The Agreement may be amended, waived or voided in writing at any time by mutual consent of the parties. If your institution retains a new vendor or merges with another Institution within the three year period your institution will be required to complete a new FIDM Agreement.

SIGNATURES:

Financial Institution:

Financial Institution Name

Contact Signature Title Date

Financial Institution Service Provider (If Applicable):

Institution Name

Agent Signature Title Date

Office of Recovery Services:

Mark L. Brasher Director, ORS Date

Tracy Graham IV-D Director, ORS Date

Mike Tazelaar Deputy Director, ORS Date

Jessica Castor Financial Institution Program Specialist Date

Office of Recovery Services
FIDM QUARTERLY TRANSMITTAL FORM
INSTITUTIONS WITH 600 OR FEWER ACCOUNTS
FOR MANUAL MATCHES ONLY

FM02

Rev. 5/06

Date Reported: _____ TIN#: _____

Institution Name: _____

Address: _____

Contact Person: _____

Phone: _____Fax: _____E-mail: _____

Number of Accounts Reported:_____Hard Copy Attached:_____

Comments:
_____
_____
_____
_____

Please return this form with each Quarterly Manual Match to:

Attention: **JESSICA CASTOR**
FIDM Program Specialist
Office of Recovery Services
PO BOX 45033
Salt Lake City UT 84145-0033
(801) 536-8902
Fax: (801) 536-8509
E-mail: orsfidm@utah.gov

Financial Institution Reimbursement Request

Rev 5/06

State of Utah

Department of Human Services
Office of Recovery Services
FM01

Reimbursement request date: _____

***NOTE: Reimbursement requests must be submitted within 30 days of the end of the quarter. Reimbursement requests received after this period will not be paid.**

Quarter in which cost was incurred: (check one)

1st Quarter: _____ 2nd Quarter: _____ 3rd Quarter: _____ 4th Quarter: ____
(Jan, Feb, Mar) (Apr, May, June) (July, Aug, Sept) (Oct, Nov, Dec)

Institution Name ***TIN/EIN***

Address **Telephone**

Institution Contact Name **Telephone**

Service Agent Name **TIN/EIN**

Address **Telephone**

Service Agent Contact Name **Telephone**

Service Agent's Signature: (person authorized to request reimbursement match)

Date:

Actual Cost of Match: $

*** NOTE: ORS WILL REIMBURSE UP TO $150 PER QUARTER**

Date Approved_____Approved by _____Date to Financial Svs. _____

Return this form to: Jessica Castor Office of Recovery Services, P.O. Box 45033, SLC, UT 84145
Phone: (801) 536-8902 Fax: (801) 536-8509 E-mail: orsfidm@utah.gov